DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.224 CONSOLIDATED HEALTH CENTERS (COMMUNITY HEALTH CENTERS, MIGRANT HEALTH CENTERS, HEALTH CARE FOR THE HOMELESS, PUBLIC HOUSING PRIMARY CARE, AND SCHOOL BASED HEALTH CENTERS)

I. PROGRAM OBJECTIVES

In general, the objective of the Consolidated Health Centers program (CHCP) is to provide to populations that would ordinarily not have access to health care (1) primary and preventive health services, (2) referrals to other services, such as hospital and substance abuse services, and (3) case management and other services designed to assist health center patients in establishing eligibility and gaining access to Federal, State, and local programs that provide additional medical, social, or educational support or enabling services, such as transportation, translation and outreach services, and patient education services.

The CHCP typically provides family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities, e.g., those where economic, geographic or cultural barriers limit access to such services for a substantial portion of the population. Some health center delivery sites serve vulnerable populations, including homeless individuals, migrant farm workers, residents of public housing, and school children at risk of poor health outcomes.

Required health services for health centers include services related to family medicine, internal medicine, pediatrics, ob/gyn, lab and radiology services, and prenatal and perinatal services; cancer screening; well-child services; immunizations; screenings for elevated blood lead, communicable diseases, and cholesterol; pediatric eye, ear, and dental screenings; voluntary family planning services; preventive dental services; emergency medical services; referrals to providers of medical services; and, as appropriate, pharmaceutical services.

Some exceptions and special provisions for certain components of the CHCP are:

Health Care for the Homeless (HCH) - In addition to services required of all consolidated health centers, recipients of HCH funding must provide substance abuse services, including detoxification, risk reduction, outpatient treatment, residential treatment, and rehabilitation for substance abuse provided in settings other than hospitals.

Specific provisions of governance requirements for HCH funding can be waived by the Health Resources and Services Administration (HRSA) under a delegation from the Secretary, Department of Health and Human Services (HHS) (see II, "Program Procedures - Administration and Services"). These requirements also may be waived under Public Housing Primary Care (PHPC) and Migrant Health Centers (MHC) components (42 USC 254b(k)(3)(H)(iii)).

Migrant Health Centers - The requirement for an MHC to provide all the primary care services can be waived, and an MHC also may receive approval to provide certain required primary health care services during certain periods of the year only. An MHC may provide health services other than primary care services due to the health needs of the population it serves. These services may include environmental health services, screening for and control of infectious diseases, and injury prevention programs.

II. PROGRAM PROCEDURES

Planning Grants

The purpose of these grants is to assess the health care needs of the population to be served and to plan and develop a health center program that will serve medically underserved populations. This includes efforts to obtain financial and professional support, develop linkages with other health-care providers, and involve the community. Planning grants also may be awarded to health centers to plan or develop a managed care network.

Operational Grants

The purpose of these grants is to support the costs of operating health centers that serve medically underserved populations. Operational grants also may include the operation of managed care and practice management networks and plans.

Administration and Services

CHCP grants are awarded and administered at the Federal level by the Bureau of Primary Health Care (BPHC), HRSA, HHS. Based on applications submitted to and approved by HRSA, grants are provided to public and private non-profit organizations. Factors considered include the population to be served and the current availability of services in the geographical area to be served.

Unless the requirement is waived, grantees are required to have a governing board that is composed of individuals, a majority of whom are being served by the center, and, who, as a group, represent the individuals being served by the center. The responsibilities of the governing board include, among other things, selecting the services to be provided, determining the center's hours of operation, and approving the selection of the center director. Grantees may enter into service and care arrangements with vendors to expand their service networks.

The annual level of HRSA funding for the operation of a health center is determined on the basis of the center's approved scope of services, projected total costs of operation, and expected revenues from program income and funding from non-Federal sources. This includes all State, local, and other operational funding received by or allocated to the approved project, and all premiums, fees, and third-party reimbursements received (adjusted for uncollectible amounts). The Federal dollars awarded are intended to make up the expected difference between the projected costs and revenues.

Source of Governing Requirements

The CHCP is authorized under Section 330 of the Public Health Service Act, as amended. The statutory provisions are codified at 42 USC 254b. The implementing program regulations for Community Health centers (CHC) and MHCs are 42 CFR parts 51c and 56, respectively. The HCH and PHPC components do not have program-specific regulations.

Availability of Other Program Information

Additional program information is available from the BPHC web site at http://www.bphc.hrsa.gov/.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. *Operational Grants for Other than Managed Care and Practice Management Networks and Plans*

   a. Required primary health services include:

      (1) Basic health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and, where appropriate, by physician assistants, nurse practitioners, and nurse midwives (42 USC 254b(b)(1)(A)(i)(I)).

      (2) Diagnostic laboratory and radiological services (42 USC 254b(b)(1)(A)(i)(II)).

      (3) Preventive health services, including prenatal and perinatal services; appropriate cancer screening; well-child services; immunizations against vaccine-preventable diseases; screenings for elevated blood lead levels, communicable diseases and cholesterol; pediatric eye, ear, and dental screenings; voluntary family planning services; and preventive dental services (42 USC 254b(b)(1)(A)(i)(III)).

      (4) Emergency medical services (42 USC 254b(b)(1)(A)(i)(IV)).

      (5) Pharmaceutical services, as may be appropriate for particular centers (42 USC 254b(b)(1)(A)(i)(V)).

(6) Referrals to providers of medical services, (including specialty referral when medically indicated) and other health-related services (including substance abuse and mental health services) (42 USC 254b(b)(1)(A)(ii)).

(7) Patient case management services (including counseling, referral, and follow-up services) and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, educational, housing, or other related services (42 USC 254b(b)(1)(A)(iii)).

(8) Services that enable individuals to use the services of the health center (including outreach and transportation services and, if a substantial number of the individuals in the population served by the center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals) (42 USC 254b(b)(1)(A)(iv)).

(9) Education of patients and the general population served by the health center regarding the availability and proper use of health services (42 USC 254b(b)(1)(A)(v)).

b. Additional health services that may be provided as appropriate to meet the health needs of the population to be served include:

(1) Behavioral and mental health and substance abuse services 42 USC 254b(2)(A); however, substance abuse services are required under HCH grants (42 USC 254b(h)(2)).

(2) Recuperative care services (42 USC 254b(b)(2)(B)).

(3) Environmental health services, including the detection and alleviation of unhealthful conditions associated with water supply, chemical and pesticide exposures, air quality, or exposure to lead; sewage treatment; solid waste disposal; rodent and parasitic infestation; field sanitation; housing; and other environmental factors related to health (42 USC 254b(b)(2)(C)).

(4) For MHCs, special occupation-related health services for migratory and seasonal agricultural workers, including screening for and control of infectious diseases (including parasitic diseases) and injury prevention programs (including prevention of exposure to unsafe levels of agricultural chemicals including pesticides) (42 USC 254b(b)(2)(D)).

c. Funds may be used for the reimbursement of members of the grantee's governing board, if any, for reasonable expenses incurred by reason of their participation in board activities (42 CFR sections 51c.107(b)(3) and 56.108(b)(3)).

d. Funds may be used for the cost of insurance for medical emergency and out-of-area coverage (42 CFR section 51c.107(b)(6)).

e. Funds may be used for the acquisition and lease of buildings and equipment (including the costs of amortizing the principal of, and paying the interest on, loans for equipment) (42 USC 254b(e)(2)).

f. Funds may be used for the costs of providing training related to the provision of required primary health care services and additional health services and to the management of health center programs (42 USC 254b(e)(2)).

2. *Planning Grants for Health Centers*

Funds may be used for the acquisition and lease of buildings and equipment (including the costs of amortizing the principal of, and paying the interest on, loans) (42 USC 254b(c)(1)(A)).

3. *Planning Grants for Managed Care or Practice Management Networks or Plans*

a. Funds may be used for the acquisition and lease of buildings and equipment, which may include data and information systems (including the costs of amortizing the principal of, and paying the interest on, loans for equipment) (42 USC 254b(c)(1)(D)).

b. Funds may be used to provide training and technical assistance related to the provision of health services on a prepaid basis or other managed care arrangement, and for other purposes that promote the development of managed care networks and plans (42 USC 254b(c)(1)(D)).

B. Allowable Costs/Cost Principles

Program income, including, but not limited to, fees, premiums and third-party reimbursements may be used for allowable activities (see III.A.1, "Activities Allowed or Unallowed - Operational Grants for Other Than Managed Care and Practice Management Networks and Plans") and for such other purposes as are not specifically prohibited if such use furthers the objectives of the project. As such, program income is subject to the unallowable cost provisions of the program rather than the OMB cost principles circulars (42 USC 254b(e)(5)(D)).

E. Eligibility

1. Eligibility for Individuals

Under HCH funding, if a grantee has provided services to a previously homeless individual and the individual is no longer homeless as a result of becoming a resident in permanent housing, the grantee may continue to provide services for not more than 12 months (42 USC 254b(h)(4)).

2. Eligibility for Group of Individuals or Area of Service Delivery - Not Applicable

3. Eligibility for Subrecipients - Not Applicable

J. Program Income

1. Health centers must have a schedule of fees or payments for the provision of their health services consistent with locally prevailing rates or charges and designed to cover their reasonable costs of operation. They are also required to have a corresponding schedule of discounts applied and adjusted on the basis of the patient's ability to pay (42 USC 254b(k)(3)(G)(i)). The patient's ability to pay is determined on the basis of the official poverty guideline, as revised annually by HHS (42 CFR sections 51c.107(b)(5), 56.108(b)(5), and 56.303(f)). The poverty guidelines are issued each year in the *Federal Register* and HHS maintains a page on the Internet that provides the poverty guidelines (http://aspe.hhs.gov/poverty/).

2. Health centers are required to collect (or make every reasonable effort to collect) appropriate reimbursement for their costs in providing health services to persons eligible for medical assistance under Title XIX of the Social Security Act (Medicaid), entitled to insurance benefits under Title XVIII of the Social Security Act (Medicare) or entitled to assistance for medical expenses under any other public assistance program or private health insurance program. Reimbursement for health services to such persons should be collected on the basis of the full amount of fees and payments for those services without application of any discount (42 USC 254b(k)(3)(F) and (G)(ii)(II)).

3. Program income, including, but not limited to, fees, premiums and third-party reimbursements may be used for allowable activities (see III.A.1. above) and for such other purposes as are not specifically prohibited if such use furthers the objectives of the project (42 USC 254b(e)(5)(D)).

L. Reporting

1. Financial Reporting

a. SF-269, *Financial Status Report* - Applicable

b. SF-270, *Request for Advance or Reimbursement* - Applicable, if specified in the terms and conditions of award.

c. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* - Not Applicable

d. SF-272, *Federal Cash Transactions Report* - Payments under this program are made by the HHS Payment Management System (PMS). Reporting equivalent to the SF-272 is accomplished through the PMS and is evidenced by the PSC-272 series of reports.

2. **Performance Reporting** - Not Applicable

3. **Special Reporting** - *Uniform Data System (OMB No. 0915-0193)* - This system is comprised of two separate sets of reports, the Universal Report and Grant Reports. The conditions for their use are:

- Grantees that receive a single grant under the consolidated health centers program or that receive CHC and/or MHC funding only are required to complete the *Universal Report* only.

- Grantees that receive multiple awards (in addition to or other than CHC and MHC funding) must complete a *Universal Report* for the combined grants and individual *Grant Reports* for their HCH and PHPC funding, if applicable.

Key Line Items - The following line items contain critical information:

a. Table 5 - Staffing and Utilization

(1) Line 8 - *Total Physicians*

(2) Line 15 - *Total Medical Care Services*

(3) Line 19 - *Total Dental Services*

(4) Line 29 - *Total Enabling Services*

(5) Line 33 - *Total Administration and Facility*

b. Table 8 Part A - Financial Costs

(1) Line 4(c) - *Total Medical Care Services*

(2) Line 10(c) - *Total Other Clinical Services*

(3) Line 13(c) - *Total Enabling and Other Services*

(4) Line 16 - *Total Overhead*

(5) Line 18 - *Value of Donated Facilities, Services, and Supplies*

c. Table 9 Part D - Patient Related Revenue

(1) Line 1 - *Medicaid Non-managed Care*

(2) Line 2a - *Medicaid Managed Care (capitated)*

(3) Line 2b - *Medicaid Managed Care (fee-for-service)*

(4) Line 7 - *Other Public including Non-Medicaid CHIP (non-managed care)*

(5) Line 10 - *Private Non-Managed Care*

(6) Line 11a - *Private Managed Care (capitated)*

(7) Line 11b - *Private Managed Care (fee-for-service)*

(8) Line 13 - *Self Pay*

N. Special Tests and Provisions

Governing Board

Compliance Requirement - Unless the requirement for a governing board is waived by HRSA or the center is operated by an Indian tribe or tribal or Indian organization under the Indian Self-Determination Act or an urban Indian organization under the Indian Health Care Improvement Act, the health center must have a governing board that (1) is composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center; (2) meets at least once a month; (3) selects the services to be provided by the center; (4) schedules the hours during which services will be provided by the center; (5) approves the center's annual budget; (6) approves the selection of a director for the center; and (7) except in the case of a public center, establishes general policies for the center (42 USC 254b(k)(3)(H)).

Audit Objectives - Determine whether (1) the center has adopted and periodically reviews and updates, as necessary, by-laws or other internal policies for governing board selection and operation; (2) the board meets at least monthly and approves the annual budget; and (3) for actions occurring during the audit period that, by statute, require governing board decision or approval, the center complied with the statute and its by-laws/internal operating procedures.

Suggested Audit Procedures

a. Ascertain if the center has by-laws or other internal policies addressing the required elements of the board and its operation.

b. Review meeting minutes to ascertain if the board approved the annual budget.

c. As of the end of the year preceding the audit, determine the board membership, services provided, operating hours, and center director. Ascertain if changes occurred in any of these areas during the audit period and, if so, whether the governing board had the type of involvement required by the statute and acted in compliance with the center's by-laws/internal operating procedures.

IV. OTHER INFORMATION

Subsequent to enactment of the Health Centers Consolidation Act of 1996 (Pub. L. No. 104-299) and related technical amendments, including the Health Care Safety Net Amendments (Pub. L. No. 107-251), the health centers programs, i.e., HCH, CHC, MHC, and PHPC, were consolidated under CFDA 93.224. Grantees were notified of the consolidation through the Program Assistance Letter 2001-22 - Web-enabled Single Grant Application for Continuation Funding under the Consolidated Health Centers Program. Program consolidation was completed in fiscal year 2002. Since that time awards have cited only CFDA 93.224. Grantees should be reporting their expenditures on the Schedule of Expenditures of Federal Awards using CFDA 93.224.